DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 4

2. STATE: MARYLAND

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Medicaid

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 1999

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
See attached

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ 9.2 million
b. FFY $

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
4.19D 1 - 7B, 10, 11

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
4.19D 1 - 7A, 10, 11

10. SUBJECT OF AMENDMENT:
This amendment is needed to implement changes to COMAR 10.09.10 Nursing Facility Services which impact reimbursement procedures.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Joseph M. Millstone, Director
Medical Care Policy Administration

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Georges C. Benjamin MD

13. TYPED NAME:
Georges C. Benjamin, M.D.

14. TITLE:
Secretary

15. DATE SUBMITTED:
December 29, 1999

16. RETURN TO:
Joseph M. Millstone, Director
Medical Care Policy Administration
Room 127
201 West Preston Street
Baltimore, Maryland 21201

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: DEC 30 1999

18. DATE APPROVED: APR 01 2000

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT 01 1999

20. SIGNATURE OF REGIONAL OFFICIAL: Claudette V Campbell

21. TYPED NAME: Claudette V. Campbell

22. TITLE: Associate Regional Administrator
Division of Medicaid & State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

4.19(d) Nursing facility payment rates are based on Maryland regulations COMAR 10.09.10 in order to account for the cost of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for Medicaid benefits. Payment rates for nursing facilities are the sum of per diem reimbursement calculations for administrative/routine, other patient care, capital, and nursing services. In addition, nursing facilities are paid for ancillary nursing procedures and therapy services for those recipients receiving these services. Payments in the aggregate may not exceed Medicare upper limits as specified at 42 CFR 447.253.

In accordance with the Omnibus Budget Reconciliation Act of 1987, nursing facility payment rates, effective October 1, 1990, take into account the costs of nursing facilities' compliance with the requirements of Sections 1919(b) (other than paragraph (3)(F)), 1919(c), and 1919(d) of the Social Security Act. Appended to this attachment is a description of the provisions which represent changes from Maryland's pre-existing requirements.

Administrative/Routine Costs

The Administrative/Routine cost center includes the following expenses: administrative, medical records, nurse aide registry fees, training, dietary, laundry, housekeeping, operation and maintenance, and capitalized organization and start-up costs. There are 4 reimbursement groups in this cost center, based on geographic location and facility size, as specified under COMAR 10.09.10.24A (which is appended to this attachment).

Providers per diem costs are calculated at the actual occupancy of the nursing facility beds or at the Statewide average occupancy of nursing facility beds plus 0.5 percent, whichever is higher, for the calculation of ceilings, current interim costs and final costs.

Although an interim Administrative/Routine rate is calculated for each provider, based on indexed cost report data, the final per diem reimbursement rate, after cost settlement, is the sum of:

(1) The provider's allowable per diem costs for covered services according to the principles of reasonable cost reimbursement established under 42 CFR Part 413, subject to the ceiling calculated for the provider's reimbursement class, and

(2) For those providers with costs below the ceiling, an efficiency allowance equal to 50 percent of the difference between the ceiling and the provider's costs, subject to a cap of 10 percent of the ceiling.

The interim per diem rates for the Administrative/Routine cost center is the sum of :

(1) The provider's indexed per diem costs subject to the ceiling calculated for the provider's reimbursement group, and

(2) For those providers with projected costs below the ceiling, 90 percent of the efficiency allowance as calculated above.

Ceilings are calculated for each of the 4 reimbursement groups. Each year all providers enrolled in the Program are required to submit a cost report within 3 months of their fiscal year end. Current administrative and routine costs are adjusted, using indices established under COMAR 10.09.10.20 (which is appended to this attachment), by indexing them from the mid-point of the provider's fiscal year to the midpoint of the State's fiscal year for which rates are being established. Indexed per diem costs are calculated by dividing indexed expenses by total days of care. The indexed per diem costs for Maryland providers are then weighted by their associated paid Medical Assistance days and the median per diem costs for each reimbursement group is determined. The maximum per diem rate is 114 percent of the median cost in each group. The ceilings are applied, as described above, to determine each provider's interim per diem payment.

Other Patient Care Costs

The Other Patient Care cost center includes expenses for providing: a medical director, pharmacy, recreational activities, patient care consultant services, raw food, social services and religious services. There are 3 reimbursement groups in this cost center, based on geographic location, as specified under COMAR 10.09.10.24B (which is appended to this attachment). Both the final per diem and interim per diem rates for the Other Patient Care cost center are determined as are those in the Administrative/Routine cost center. (Indices for Other Patient Care are established under COMAR 10.09.10.21 which is appended to this attachment.) Ceiling calculations are also identical except that the maximum per diem rate is 120 percent of the projected per diem cost in each group. For providers with costs below the ceiling, the efficiency allowance is 25 percent of the difference between the ceiling and the provider's costs, subject to a cap of 5 percent of the ceiling.

Therapy Services

Reimbursement for therapy services will be determined as follows:

(1) Physical, occupational and speech therapy services will be reimbursed in 15 minute increments with a maximum per diem duration of 1 hour.

(2) Reimbursement rates shall be calculated as a percent of an hourly rate comprised of two components from the Medicare Therapy Services Guidelines and a per diem supply cost. The hourly rate shall be the sum of:

(a) The adjusted hourly salary equivalent amount for the type of therapy service effective for the period corresponding to the State fiscal year from the Medicare guidelines;
(b) One sixth of the total travel allowance for the period corresponding to the State fiscal year from the Medicare guidelines; and
(c) A supply allowance established at $.30 for the period October 1, 1999 through June 30, 2000 and indexed in subsequent years based on the Consumer Price Index for All Urban Consumers (CPI-U), nonprescription medical equipment and supplies component from the U. S. Department of Labor Statistics, CPI Detailed Report, Table 4.

(3) Reimbursement rates shall be established at 25 percent of the hourly rate for a 15 minute therapy session, 50 percent of the hourly rate for a 30 minute therapy session, 75 percent of the hourly rate for a 45 minute therapy session and 100 percent of the hourly rate for a 60 minute therapy session.

(4) Providers shall be reimbursed based upon the Medicare Therapy Services Guidelines established for the geographic area in which the provider is located.

(5) Reimbursement for therapy services is not subject to cost settlement.

Capital Costs

Interim capital per diem payment is the sum of net capital value rental and the per diem for recurring costs including: taxes, allowable interest, insurance and central office capital costs.

A facility's net capital value rental per diem component is calculated as follows. At a minimum of every 4 years, each facility's building(s), nonmovable equipment and land are appraised. Using indices established by regulation, these appraisal amounts are indexed to the midpoint of the State fiscal year for which rates are being set. (Building value and nonmovable equipment are indexed by Quarterly Index for Construction, Baltimore, from Marshall Valuation Service - mean of indices for reinforced concrete and masonry bearing walls. Land value is indexed by Maryland land value statistics from the Bureau of Appraisal Review, Office of Real Estate, State Highway Administration, Department of Transportation. See COMAR 10.09.10.22 which is appended to this attachment.) The per bed value is subject to a ceiling which is adjusted each year based on indices established in regulation. (Quarterly Index for Construction, Baltimore, from Marshall Valuation Service - mean of indices for reinforced concrete and masonry bearing walls. See COMAR 10.09.10.22 which is appended to this attachment.) The resulting allowable per bed value is then increased by adding an equipment allowance which is also indexed each year based on indices set in regulation. (Quarterly Index for Hospital Equipment from Marshall Valuation Service. See COMAR 10.09.10.22 which is appended to this attachment.) The facility's allowable debt, that amount that does not exceed allowable capital value, is subtracted from the allowable capital value to arrive at the facility's net capital value. Net capital value is multiplied by the appropriate rental rate established at COMAR 10.09.10.10L(10) (which is appended to this attachment) to arrive at the provider's total net capital value rental. The per diem payment is derived by dividing this amount by the actual occupancy of the nursing facility beds plus 95 percent of licensed capacity of the non-nursing facility beds, or the Statewide average occupancy of nursing facility beds plus 0.5 percent, plus 95 percent of licensed capacity of the non-nursing facility beds, whichever is higher.

For leased facilities, the above procedure is modified as follows. A debt amount is calculated based on the assumptions that the original portion mortgaged was equal to 85 percent of the appraised value at the time the provider's original lease for the facility was executed, and that the mortgage was taken for a 20 year period with amortization calculated with constant payments. A mortgage interest rate is calculated using indices established at COMAR 10.09.10.10I (which is appended to this attachment).

A facility's recurring capital cost per diem component is calculated as follows. The sum of all recurring costs: taxes, insurance, allowable interest (interest on mortgage debt that does not exceed the facility's allowable capital value) and central office capital costs, are divided by actual occupancy of the nursing facility beds or the Statewide average occupancy of nursing facility beds plus 0.5 percent, whichever is higher. For leased facilities, taxes and insurance costs are included whether paid by the lessor or the lessee.

The interim capital per diem payment is subject to final reconciliation at cost settlement.

Nursing Service Cost Center

Nursing Service rates are established for each of 6 levels of care (light, light behavior management, moderate, moderate behavior management, heavy and heavy special) and the following ancillary procedures: decubitus ulcer care, support surfaces for pressure ulcer care, communicable disease care, central intravenous line, peripheral intravenous care, ventilator care, tube feeding, turning and positioning, ostomy, oxygen/aerosol therapy, suction/tracheotomy, single injections and multiple injections. Levels of care are based on a patient's dependency in the 5 activities of daily living (feeding, continence, mobility, dressing and bathing) and need for behavior management. The levels of care are defined as follows:

Light Care	- Patient is dependent in 0-2 activities
Light Care Behavior Management	- Patient is dependent in 0-2 activities and has documented behavior management problems
Moderate Care	- Patient is dependent in 3-4 activities
Moderate Care Behavior Management	- Patient is dependent in 3-4 activities and has documented behavior management problems
Heavy Care	- Patient is dependent in all 5 activities
Heavy Special Care	- Patient is Heavy Care and requires one or more of the following ancillary procedures: - decubitus ulcer care - support surfaces for pressure ulcer care - communicable disease care - central intravenous line - peripheral intravenous care - ventilator care - tube feeding

Nursing rates are computed for 5 geographic regions as specified under COMAR 10.09.10.24C (which is appended to this attachment). Therefore 5 reimbursement rates are established for each level of care (ADL classification) and ancillary procedure. The precise method is as follows.

Each year every Maryland nursing home enrolled in the Program, unless specifically exempted due to low Medicaid occupancy, submits a wage survey which reports the wage rate(s) and associated hours for each nursing staff performing nursing services during a designated pay period. These staff are identified in 5 nursing staff occupation groups: Directors of Nursing, Registered Nurses, Licensed Practical Nurses, Nurse Aides and Certified Medication Aides. For each nursing region and occupation group, the wage rate at the 75th percentile of hours worked is selected.

These selected wages are indexed to the midpoint of the rate year, using salary and wage indices specified under COMAR 10.09.10.23 (which is appended to this attachment). Regional fringe benefit factors are then applied to the indexed wages to compute an hourly rate that includes wages plus benefits. These adjusted wages are used as the foundation for calculating nursing rates for the ADL classifications and ancillary procedures.

Each ADL classification and ancillary procedure requires a specific amount of nursing staff time per day, based upon a work measurement study and staffing information from the wage survey. These data also determine the percentage of time each occupation group is involved in each ADL classification and procedure.

Reimbursement for the nursing time required for the ADL classifications and ancillary procedures is calculated by multiplying the daily hours required by the personnel category weight, multiplying the product by that personnel category's adjusted wage, and summing the results for each level of care and procedure in each nursing region. As an incentive for providers to serve heavier care patients, this nursing time rate for specified ADL classifications and procedures is modified by multiplying the rate by an incentive factor as listed below.

Level of Care/Procedure	Incentive Factor
Moderate Care	1.02
Moderate Care – Behavior Management	1.02
Heavy Care	1.03
Heavy Special Care	1.04
Decubitus Ulcer Care	1.04
Tube Feeding	1.04
Communicable Disease Care	1.04
Central Intravenous Line	1.04
Peripheral Intravenous Care	1.04
Ventilator Care	1.04

The above described "nursing time rates" (not including the amount of the incentive factors) are also subjected to the following adjustments:

The nursing time rate for communicable disease care is multiplied by 0.4 to determine an adjustment amount to allow for the recruitment and special training of staff and for the cost of supplies associated with this procedure. This amount is added to the nursing time rate as modified by the above incentive factor to establish the rate for "communicable disease care - level 1."

In order to establish the reimbursement rate for "communicable disease care - level 2," for patients who require communicable disease care and who are in licensed comprehensive care beds which are also licensed as acute or special hospital beds, the nursing time rate for communicable disease care is multiplied by 1.4 to determine an adjustment amount to allow for the recruitment and special training of staff, the cost of supplies associated with this procedure, and for costs related to maintaining a higher level of certification for those beds. This amount is added to the nursing time rate as modified by the above incentive factor for communicable disease care.

The nursing time rate for central intravenous line is multiplied by 0.5 to determine an adjustment amount to allow for the recruitment and special training of staff associated with this procedure. This amount is added to the nursing time rate as modified by the above incentive factor for central intravenous line.

The rate for ventilator care is the sum of the following:

(1) the nursing time rate multiplied by the above incentive factor for ventilator care;

(2) the nursing time rate for ventilator care (not including the incentive factor adjustment) multiplied by 0.6 to establish an amount to allow for the recruitment and special training of staff, and the cost of supplies and equipment associated with this procedure;

(3) an amount for respiratory therapy determined from the mean hourly wage including fringe benefits for respiratory therapists in Maryland hospitals, from the Maryland Health Services Cost Review Commission Annual Wage Survey, multiplied by 3.75;

(4) the average per diem cost for a respirator support system is determined from the fee schedule for respirator equipment established in accordance with COMAR 10.09.27 Expanded EPSDT Referred Services; and

(5) an amount for medical director determined from the conversion factor for nonsurgical services used by the Health Care Financing Administration for calculation of physician reimbursement based upon relative units, multiplied by 0.25.

Reimbursement for specialized support surfaces for pressure ulcer care is determined as follows:

(1) A Class A support surface is a mattress replacement which has been approved as a Group 2 Pressure Reducing Support Surface by the Medical Policy of the Medicare Durable Medical Equipment Regional Carrier. A Class A support surface will be reimbursed per day at the Medicare Durable Medical Equipment Regional Carrier Maryland monthly fee cap, in effect at the beginning of the State fiscal year, for HCPCS Code E0277 multiplied by 12 and then divided by the number of days in the State fiscal year.

(2) A Class B support surface is an air fluidized bed which has been approved as a Group 3 Pressure Reducing Support Surface by the Medical Policy of the Medicare Durable Medical Equipment Regional Carrier. A Class B support surface will be reimbursed per day at the Medicare Durable Medical Equipment Regional Carrier Maryland monthly fee cap, in effect at the beginning of the State fiscal year, for HCPCS Code E0194 multiplied by 12 and then divided by the number of days in the State fiscal year.

Additional adjustments are made to account for supply costs. (Indices for supplies are established under COMAR 10.09.10.23) A weighted mean indexed Statewide per diem expenditure for nursing supplies from the uniform cost report is calculated and added to the rates for the 6 ADL classification per diem rates. The indexed wholesale cost for Ensure Formula, and the indexed wholesale cost of tubing, is added to the rates established for tube feeding for recipients who are not eligible for these services under Title XVIII of the Social Security Act. The indexed wholesale cost for sterile dressings is added to the rates established for decubitus ulcer care.

Payment for nursing service is made at standard rates as determined above and are based on patient assessments undertaken in each facility by the Utilization Control Agent in order to ascertain the days of each type of procedure received by, and the ADL classification of, each Medical Assistance resident.

When an improvement in ADL classification is achieved by a facility for a resident who has been at the prior (higher) ADL classification for a minimum of 2 consecutive months, reimbursement for that resident will continue at the prior (higher) ADL classification until discharge, transfer, a return to the prior (higher) ADL classification, or for 2 subsequent months, whichever is less, in order to provide a transitional staffing adjustment to the facility in the amount of the difference between the reimbursement associated with the prior (higher) and the current (lower) ADL classifications.

Interim nursing payments are reduced for any provider which, based upon the most recently desk review actual allowable costs, is projected to spend less than 85 percent of its standard per diem rates. A rate reduction factor is calculated as 50 percent of the percentage, up to 20 percent, by which the provider is projected to underspend its standard per diem rates, and the entire percentage of the rates projected to be unspent in excess of 20 percent.

The interim nursing service payment is subject to cost settlement. Providers will be allowed their costs, plus 5 percent of the standard rate, up to the maximum (standard) payment amount. The above-mentioned percentage adjustments for communicable disease care and central intravenous line are not subject to cost settlement.

A provider that renders care to Maryland Medicaid recipients on 1,000 or less days of care during the provider's fiscal year may choose to not be subject to cost reporting or field verification requirements and choose to accept as payment the projected Medicaid statewide average payment for each day of care. Any provider choosing this option is exempt from the subsequent nursing cost center wage survey.

Intermediate Care Facilities for the Mentally Retarded are a separate class and such facilities are reimbursed reasonable costs. The determination of reasonable costs is based on Medicare principles of reasonable cost as described at 42 CFR 413. An average cost per day for provider-based physician services is developed and paid in accordance with retrospective cost reimbursement principles. Payments in the aggregate may not exceed Medicare upper limits as specified at 42 CFR 447.272..

COMAR 10.09.10.10L

L. The net capital value rental for those facilities which are subject to rate determination under §C of this regulation is determined through he following steps:

(1) The Department or its designee shall appraise the value of the building and non-movable equipment of each facility at least every 4 years using a "segregated cost" approach to determining reconstruction cost minus any physical deterioration and functional obsolescence as estimated through the "breakdown" method. Actual indexed construction costs in whole or in part which are 5 years old or less shall be used to the extent available in preference to the application of the "segregated cost" methodology.

(2) The Department or its designee shall appraise the value of the land of each facility at least every 4 years using a market value approach considering its highest valued use as a nursing home.

(3) If the provider elects to protest an appraisal under §L(1) or (2) of this regulation, written notification shall be filed with the Department within 90 days of receipt of the appraisal. Any protest which cannot be resolved administratively shall be turned over to the appeal board for review under the provisions of Regulation .14D of this chapter.

(4) The allowable portion of the combined appraised value for land, building, and nonmovable equipment may not exceed a specified limit. This limit shall be established at $44,400 per licensed bed effective December 31, 1999 and shall be indexed forward as determined from §J of this regulation.

(5) Facilities owned by the State need not be appraised, but shall have their capital values set at the limit established in §L(4) of this regulation. Under the provisions of §F of this regulation, facilities owned by the State shall be assumed to have no debt.

(6) The allowance for movable equipment shall be:

(a) Established at $4,500 per licensed bed effective December 31, 1999;

(b) Indexed forward as determined from §J of this regulation; and

(c) Added to the appraised value determined from §L(1), (2), (4), and (5) of this regulation.

(7) The allowance for movable equipment will exclude all items which:

(a) Are regularly replenished or stocked, consumed in their use or have a one-time use, or useful for a lifetime of less than 2 years; or

(b) Have an historical or aggregate historical cost of less than $500.

(8) The amount of the allowable mortgage debt as of the midpoint of the fiscal year shall be subtracted from the allowable appraised value from §L(6) of this regulation in order to establish the value of the net capital.

(9) The debt information to be used in §L(8) of this regulation shall be supplied to the Department or its designee by each facility in the form of a monthly amortization schedule within 60 days of the establishment of the debt.

(10) The value of net capital from §L(8) of this regulation shall be multiplied by 0.089 in order to generate the net capital value rental.